

6796

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Garrett</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Garrett</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakland</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>D O A, at Garrett Co. Mem. Hosp.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Joseph</b> Middle <b>Larry</b> Last <b>Brandt</b>		4. DATE OF DEATH <b>June 12, 1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 4, 1904</b>
9. AGE (In years last birthday) <b>55</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Welder &amp; Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Farm</b>	
11. BIRTHPLACE (State or foreign country) <b>Michigan</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James J. Brandt</b>		14. MOTHER'S MAIDEN NAME <b>Nancy Ellen Green</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>234-62-2593</b>	
17. INFORMANT <b>Mrs. Joseph Brandt-R.D. Gorman, W. Va.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asphyxiation</b> <b>162.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. } (b) <b>Tracheal Obstruction</b> (c) <b>Bronchogenic Carcinoma, with generalized metastases</b>			INTERVAL BETWEEN ONSET AND DEATH <b>0</b> <b>1-2 minutes</b> <b>12-18 months</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>February</b> , 19 <b>59</b> , to <b>June</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>May 15</b> , 19 <b>59</b> , and that death occurred at <b>7:05 A.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Richard F. Leighton</b> M.D.		ADDRESS (Street, city or town, state) <b>5th &amp; Oak Sts., Oakland, Md.</b> DATE SIGNED <b>6/12/1959</b>	
PHYSICIAN'S NAME (Type) <b>Richard F. Leighton, M. D.</b>		<b>Oakland, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/14/1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Gregory Family Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Red Oak, Garrett Co., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>R. F. Leighton</b>		ADDRESS <b>Oakland, Md.</b>	
24a. REC'D BY REGISTRAR <b>JUN 16 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed, Pages 1 and 2 should be filled with the information requested. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. Name of deceased: \_\_\_\_\_

2. Sex: \_\_\_\_\_

3. Age: \_\_\_\_\_

4. Date of birth: \_\_\_\_\_

5. Place of birth: \_\_\_\_\_

6. Date of death: \_\_\_\_\_

7. Time of death: \_\_\_\_\_

8. Cause of death: \_\_\_\_\_

9. Place of death: \_\_\_\_\_

10. Signature of physician: \_\_\_\_\_

11. Signature of registrar: \_\_\_\_\_

12. Signature of informant: \_\_\_\_\_

13. Name of informant: \_\_\_\_\_

14. Address of informant: \_\_\_\_\_

15. Date of filing: \_\_\_\_\_

16. File number: \_\_\_\_\_

17. Registrar's office: \_\_\_\_\_

18. County: \_\_\_\_\_

19. State: \_\_\_\_\_

20. City: \_\_\_\_\_

21. Zip: \_\_\_\_\_

22. Telephone: \_\_\_\_\_

23. Fax: \_\_\_\_\_

24. E-mail: \_\_\_\_\_

25. Website: \_\_\_\_\_

26. Social Security Number: \_\_\_\_\_

27. Driver's License Number: \_\_\_\_\_

28. Voter Registration Number: \_\_\_\_\_

29. Marital Status: \_\_\_\_\_

30. Education: \_\_\_\_\_

31. Occupation: \_\_\_\_\_

32. Religion: \_\_\_\_\_

33. Race: \_\_\_\_\_

34. Ethnicity: \_\_\_\_\_

35. Ancestry: \_\_\_\_\_

36. Languages spoken: \_\_\_\_\_

37. Hobbies: \_\_\_\_\_

38. Pets: \_\_\_\_\_

39. Medical history: \_\_\_\_\_

40. Current medications: \_\_\_\_\_

41. Allergies: \_\_\_\_\_

42. Recent travel: \_\_\_\_\_

43. Insurance: \_\_\_\_\_

44. Financial status: \_\_\_\_\_

45. Family members: \_\_\_\_\_

46. Friends: \_\_\_\_\_

47. Community involvement: \_\_\_\_\_

48. Other information: \_\_\_\_\_

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death: Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06787

6797

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>GARRETT</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>WEST VIRGINIA</b> b. COUNTY <b>MINERAL</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OAKLAND</b>		c. LENGTH OF STAY IN 1b <b>7 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>GARRETT COUNTY MEMORIAL HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>HERBERT</b> Middle <b>T.</b> Last <b>DAWSON</b>		4. DATE OF DEATH Month <b>JUNE</b> Day <b>19</b> Year <b>1959</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/11/1887</b>
9a. AGE (In years last birthday) <b>71</b> yrs.		9b. IF UNDER 1 YEAR Months <b>19</b> Days <b>19</b> Hours <b>59</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MAIL CARRIER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Rural Contract</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>WILLIAM THOMAS DAWSON</b>		14. MOTHER'S MAIDEN NAME <b>ELIZABETH BAILEY</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>236-12-2574</b>	
17. INFORMANT <b>LILLIE DAWSON</b>		Address <b>SHAW, WEST VIRGINIA</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerosis</b> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b> <b>years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>6-12</b> , 19 <b>59</b> , to <b>6-19</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>6-19-59</b> , 19 <b>59</b> , and that death occurred at <b>2:15 P.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>James H. Feaster, Jr.</b>		DATE SIGNED <b>6.20.59</b>	
PHYSICIAN'S NAME (Type) <b>JAMES H. FEASTER, JR., M.D.</b>		ADDRESS (Street, city or town, state) <b>SECOND STREET OAKLAND, MARYLAND</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/22/1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Ebenezer Church Cemetery, Romney, W. Va.</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. C. Leighton</b>		ADDRESS <b>Oakland, Md.</b>	
24a. REC'D BY REGISTRAR <b>Arthur S. Hines</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH	
5. PLACE OF BIRTH		6. OCCUPATION		7. MARITAL STATUS		8. COLOR	
9. PLACE OF DEATH		10. CAUSE OF DEATH		11. MANNER OF DEATH		12. TIME OF DEATH	
13. SIGNATURE OF PHYSICIAN		14. SIGNATURE OF REGISTRAR		15. SIGNATURE OF WITNESS		16. SIGNATURE OF DECEASED	
17. DATE OF DEATH		18. TIME OF DEATH		19. PLACE OF DEATH		20. COUNTY	
21. CITY		22. STATE		23. ZIP CODE		24. COUNTY	
25. SIGNATURE OF PHYSICIAN		26. SIGNATURE OF REGISTRAR		27. SIGNATURE OF WITNESS		28. SIGNATURE OF DECEASED	
29. DATE OF DEATH		30. TIME OF DEATH		31. PLACE OF DEATH		32. COUNTY	
33. CITY		34. STATE		35. ZIP CODE		36. COUNTY	
37. SIGNATURE OF PHYSICIAN		38. SIGNATURE OF REGISTRAR		39. SIGNATURE OF WITNESS		40. SIGNATURE OF DECEASED	
41. DATE OF DEATH		42. TIME OF DEATH		43. PLACE OF DEATH		44. COUNTY	
45. CITY		46. STATE		47. ZIP CODE		48. COUNTY	
49. SIGNATURE OF PHYSICIAN		50. SIGNATURE OF REGISTRAR		51. SIGNATURE OF WITNESS		52. SIGNATURE OF DECEASED	
53. DATE OF DEATH		54. TIME OF DEATH		55. PLACE OF DEATH		56. COUNTY	
57. CITY		58. STATE		59. ZIP CODE		60. COUNTY	
61. SIGNATURE OF PHYSICIAN		62. SIGNATURE OF REGISTRAR		63. SIGNATURE OF WITNESS		64. SIGNATURE OF DECEASED	
65. DATE OF DEATH		66. TIME OF DEATH		67. PLACE OF DEATH		68. COUNTY	
69. CITY		70. STATE		71. ZIP CODE		72. COUNTY	
73. SIGNATURE OF PHYSICIAN		74. SIGNATURE OF REGISTRAR		75. SIGNATURE OF WITNESS		76. SIGNATURE OF DECEASED	
77. DATE OF DEATH		78. TIME OF DEATH		79. PLACE OF DEATH		80. COUNTY	
81. CITY		82. STATE		83. ZIP CODE		84. COUNTY	
85. SIGNATURE OF PHYSICIAN		86. SIGNATURE OF REGISTRAR		87. SIGNATURE OF WITNESS		88. SIGNATURE OF DECEASED	
89. DATE OF DEATH		90. TIME OF DEATH		91. PLACE OF DEATH		92. COUNTY	
93. CITY		94. STATE		95. ZIP CODE		96. COUNTY	
97. SIGNATURE OF PHYSICIAN		98. SIGNATURE OF REGISTRAR		99. SIGNATURE OF WITNESS		100. SIGNATURE OF DECEASED	

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 6798 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06788

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Garrett</b> <span style="float: right;">MARYLAND</span>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Garrett</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Gorman</b>			c. LENGTH OF STAY IN 1b <b>80 yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Gorman</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <b>7</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>DANIEL ANDREW EGER</b> <div style="text-align: center;">First Middle Last</div>				4. DATE OF DEATH <b>JUNE 27 19 59</b> <div style="text-align: center;">Month Day Year</div>				
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>unk/unk/1870</b>		
9. AGE (In years last birthday) <b>89</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farming</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Daniel Eger</b>				14. MOTHER'S MAIDEN NAME <b>Barbara Yockum</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Mrs. Ruth Miller</b> Address <b>Tacoma Park, Md.</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION, ACUTE</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause last. DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <b>IMMEDIATE</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE <b>James H. Feaster, Jr.</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) <b>JAMES H. FEASTER, JR., M. D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/30/1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Pope Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Gorman Maryland</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Gerald N. Minnich Oakland, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>JUL 6 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. House</b>		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.





## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06789

6799

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Garrett</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <b>Maryland</b> b. COUNTY <b>Garrett</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakland,</b>		c. LENGTH OF STAY IN 1b <b>27 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>D O A Oakland Hospital</b>		d. STREET ADDRESS <b>Second Street</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Ray</b> Middle <b>Leibowitz</b> Last <b>Feld</b>		4. DATE OF DEATH Month <b>June</b> Day <b>30</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 29, 1890</b>
9. AGE (In years last birthday) yrs. <b>69</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>house work</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Joseph Leibowitz</b>		14. MOTHER'S MAIDEN NAME <b>Lena Glass</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT <b>Irvin Feld</b>		Address <b>Oakland, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.1 Acute Myocardial Insufficiency</b> DUE TO (b) <b>Arteriosclerotic Cardio Vascular Disease</b> DUE TO (c) <b>20 years</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>11:50P</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March</b> , 19 <b>57</b> , to <b>June</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>June 5</b> , 19 <b>59</b> , and that death occurred at <b>11:50P</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Herbert H. Leighton</b> M.D.		ADDRESS (Street, city or town, state) <b>77 Oak Street, Oakland, Md.</b> DATE SIGNED <b>July 1, 1959</b>	
PHYSICIAN'S NAME (Type) <b>Herbert H. Leighton, M. D.</b>		<b>Oakland, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/3/1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Mogen Abraham Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Rosedale, Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. C. Leighton</b> ADDRESS <b>Oakland, Md.</b>		24a. REC'D BY REGISTRAR <b>JUL 6 '59</b> 24b. REGISTRAR'S SIGNATURE <b>Arthur S. K...</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

See Ord. 10

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES M. ROY		45		M		W		1880		BALTIMORE, MD.	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH	
1234 E. BALTIMORE ST.		CLOCK REPAIRER		HEART DISEASE		NATURAL		JAN 15, 1925		BALTIMORE, MD.	
FATHER		MOTHER		SPOUSE		CHILDREN		EDUCATION		RELIGION	
JAMES M. ROY		MARY J. ROY		JANE ROY		JOHN ROY		HIGH SCHOOL		METHODIST	
BROTHERS		SISTERS		PREVIOUS ILLNESS		TREATMENT		BURIAL		FUNERAL	
JOHN ROY		MARY ROY		NONE		NONE		NONE		NONE	
DATE OF INTERVIEW		INTERVIEWER		SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN		SIGNATURE OF CLERK	
JAN 15, 1925		J. M. ROY		J. M. ROY		J. M. ROY		J. M. ROY		J. M. ROY	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6800

## CERTIFICATE OF DEATH

06790

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Garre tt MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland Rt# 2		c. LENGTH OF STAY IN 1b unk	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Oakland Rt# 2		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	
d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Emma Christine Frazee		4. DATE OF DEATH Month 6 Day 29 Year 19 59	
5. SEX Femal	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/25/1893
9. AGE (In years last birthday) 66 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) domestic		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Accident, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Edward Margroff		14. MOTHER'S MAIDEN NAME Hanna Fredick	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mr. Carl Frazee		Address Oakland Rt# 2, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 451X Aneurysm, Ruptured DUE TO (b) Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH Sudden	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5-3-1958 to 6-29-1959, that I last saw the deceased alive on 6/26, 1959, and that death occurred at 9:45 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Andrew S. Mance M.D.		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) A.E. MANCE, M.D.		OAKLAND, MARYLAND 30/July 1959	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 7/2/1959	
22c. NAME OF CEMETERY OR CREMATORY Oakland Cemetery		22d. LOCATION (City, town, or county) (State) Oakland Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Gerald N. Minnich		ADDRESS Oakland, Maryland	
24a. REC'D BY REGISTRAR DATE JUL 6 '59		24b. REGISTRAR'S SIGNATURE Clara S. Frank	

WILLIAM B. ROID

CERTIFICATE OF DEATH

MARY AND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
RESIDENCE		BIRTH PLACE		EDUCATION		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
DATE OF BIRTH		PLACE OF BIRTH		MARRIAGE		PREVIOUS DEATHS		HISTORY OF ILLNESS		TREATMENT	
DATE OF DEATH		PLACE OF DEATH		HOURS OF DEATH		TEMPERATURE		PULSE		RESPIRATION	
SIGNATURE OF PHYSICIAN		SIGNATURE OF WITNESSES		SIGNATURE OF DECEASED		SIGNATURE OF FUNERAL HOME		SIGNATURE OF BURIAL PLACE		SIGNATURE OF STATE DEPARTMENT OF HEALTH	
DATE OF SIGNATURE		PLACE OF SIGNATURE		DATE OF SIGNATURE		PLACE OF SIGNATURE		DATE OF SIGNATURE		PLACE OF SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital. The attending physician. TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, it should be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6801

## CERTIFICATE OF DEATH

06791

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Garrett</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Garrett</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>McHenry, Md.</u>		c. LENGTH OF STAY IN 1b <u>15 MONTHS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>KLOTZ</u> Last <u>KLOTZ</u>		4. DATE OF DEATH Month <u>June</u> Day <u>9</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr. 14, 1879</u>
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own farm</u>	
11. BIRTHPLACE (State or foreign country) <u>Bittering, Garrett Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Christian Klotz</u>		14. MOTHER'S MAIDEN NAME <u>Mary Pope</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>216-38-1942</u>	
17. INFORMANT <u>Raymond Klotz, McHenry, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> DUE TO <u>Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) <u>  </u>			
INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>10 years</u> <u>10 years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May</u> , 19 <u>58</u> , to <u>June 9</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>June 8</u> , 19 <u>59</u> , and that death occurred at <u>5:30</u> A. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>C. W. Stotler, MD.</u>		ADDRESS (Street, city or town, state) <u>349 Main St. Meyersdale, Pa.</u> DATE SIGNED <u>6/10/59</u>	
PHYSICIAN'S NAME (Type) <u>C. W. STOTLER, MD.</u>		<u>349 MAIN ST. MEYERSDALE, PA.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6/12/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Accident</u>	22d. LOCATION (City, town, or county) (State) <u>Accident Garrett Co., Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lois Newman</u>		ADDRESS <u>Grantsville, Md.</u>	
24a. REC'D BY REGISTRAR <u>  </u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

1500

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this death certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

6802

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06792

# CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH COUNTY <b>GARRETT</b> CITY (If outside corporate limits, write RURAL and give nearest town) <b>KITZMILLER</b> TOWN <b>KITZMILLER</b>				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <b>MARYLAND</b> COUNTY <b>GARRETT</b> CITY (If outside corporate limits, write RURAL and give nearest town) <b>KITZMILLER</b> OR TOWN <b>KITZMILLER</b> STREET ADDRESS (If rural give location) <b>MAIN STREET</b>			
3. NAME OF DECEASED (Type or Print) <b>MAUDE</b> (First) <b>ELIZABETH</b> (Middle) <b>KNOTTS</b> (Last)				4. DATE OF DEATH <b>JUNE 17 1959</b> (Month) (Day) (Year)			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>APRIL 8, 1882</b>	9. AGE last birthday <b>77</b> yrs.	10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>H C CLEWORK</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>		11. BIRTHPLACE (State or foreign country) <b>WEST VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JAMES EVERETT</b>				14. MOTHER'S MAIDEN NAME <b>ALICE DULEY</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unk.) <b>NO</b>		16. SOCIAL SECURITY NO. <b>216-09-2792B</b>		17. INFORMANT & ADDRESS <b>Elza Knotts, Kitzmiller, Md.</b>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
331X IMMEDIATE CAUSE (A) <b>Acute Myocardial Infarction</b>						<b>3 days</b>	
ANTECEDENT CAUSE(S) DUE TO (B) <b>Cerebral Thrombosis with rt sided paralysis</b>						<b>5 yrs</b>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <b>Fracture of rt hip</b>						<b>8 yrs</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>Feb 7, 1951</b> , to <b>June 17, 1959</b> , that I last saw the deceased alive on <b>June 17, 1959</b> , and that death occurred at <b>9:50 P.M.</b> from the causes and on the date stated above.							
SIGNATURE <b>Ralph Calandulla</b> M.D.				ADDRESS (Street, city, town, state) <b>Kitzmillers Md</b>		DATE SIGNED <b>June 18-59</b>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>6/20/59</b>		NAME OF CEMETERY OR CREMATORY <b>I.O.O.F. Cemetery</b>		LOCATION (City, town, or county) (State) <b>Elk Garden, W.Va.</b>	
24. REC'D BY REGISTRAR DATE <b>JUN 22 '59</b>		REGISTRAR'S SIGNATURE <b>Arthur S. House</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>H.C. Leggett</b>		ADDRESS <b>Oakland, Md.</b>	



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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6803

## CERTIFICATE OF DEATH

Reg. Dist. No.

06793

1. PLACE OF DEATH a. COUNTY <b>Garrett</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland.</b> b. COUNTY <b>Garrett</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Oakland</b>		c. LENGTH OF STAY IN 1b <b>38 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>near Red House</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Floyd</b> Middle <b>Lee</b> Last <b>Lee</b>		4. DATE OF DEATH Month <b>June</b> Day <b>29</b> , Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 30, 1875</b>
9. AGE (In years last birthday) <b>83</b> yrs.		10. IF UNDER 1 YEAR Months <b>8</b> Days <b>29</b> Hours <b>15</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Farm</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Perry Lee</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Moreland</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>212-38-6196</b>	
17. INFORMANT <b>Earl Lee</b>		Address <b>Oakland, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>151X Carcinomatosis - Metastatic</b> DUE TO <b>Carcinoma of Stomach</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Intestinal Sclerosis</b> DUE TO <b>Intestinal Sclerosis</b> (c) <b>Intestinal Sclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>8 weeks</b> <b>8 months</b> <b>6 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>2-28-</b> , 19 <b>58</b> , to <b>6-29</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>6-11-</b> , 19 <b>59</b> , and that death occurred at <b>7:25 A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Oakland, Md.</b> DATE SIGNED <b>30 June 59</b>			
ACTUAL SIGNATURE <b>Andrew E. Mance</b> M.D.		PHYSICIAN'S NAME (Type) <b>Andrew E. Mance, M. D.</b> <b>Oakland, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/2/1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Red House Church Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Garrett C., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. A. Righton</b>		ADDRESS <b>Oakland, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>JUL 6 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Evans</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician. TO FUNERAL DIRECTOR OR: After the death certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE  
HEALTH DEPT.

6804 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06794

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Garrett</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oakland</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Garrett County Memorial Hospital</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland.</u> b. COUNTY <u>Garrett</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Star Route, Oakland,</u> d. STREET ADDRESS <u>6 Mi. N. Oakland</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Michael</u> Last <u>Long</u>		4. DATE OF DEATH Month <u>June</u> Day <u>18,</u> Year <u>1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 12, 1883</u>	9. AGE (In years last birthday) <u>75</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Farm</u>		11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Adam H. Long</u>		14. MOTHER'S MAIDEN NAME <u>Anna Catherine Bloss</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>218-12-5966</u>		17. INFORMANT <u>Lonnie Long</u> Address <u>Star Route, Oakland, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion, right</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary osteal sclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> ----
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>James H. Feaster Jr.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>6.19.59</u>	
EXAMINER'S NAME (Type) <u>James H. Feaster Jr., M. D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/21/1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Deer Park Cemetery</u>	
				22d. LOCATION (City, town, or county) (State) <u>Deer Park, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. R. Leighton</u>		ADDRESS <u>Oakland, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 22 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Huang</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 should be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.





# 1 6805 Item 2 Film 6244 7-7-59 et 6805 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 CERTIFICATE OF DEATH 06795 Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Garrett</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dakota</u> c. LENGTH OF STAY IN 1b <u>7 mo</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Casper's Nursing Home</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Penna.</u> b. COUNTY <u>Garrett</u> ✓ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dakota</u> <u>Hyndman</u> <u>75x-3</u> d. STREET ADDRESS <u>1001 1st St</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>WILLIAM</u> First Middle Last <u>LOWERY</u>		4. DATE OF DEATH Month <u>JUNE</u> Day <u>25</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/17/1882</u>
9. AGE (In years last birthday) <u>76</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Railroad employee</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>	
11. BIRTHPLACE (State or foreign country) <u>Cooks Mills, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Fillmore Lowery</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Albright</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Mr. Charles Sisler, Hyndman, Pa.</u>	
17. INFORMANT <u>Mr. Charles Sisler, Hyndman, Pa.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolism</u> <u>465X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Venous ulcers</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Hour a. m. _____ p. m. _____ Month _____ Day _____ Year <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>Nov 15, 1958</u> to <u>June 25, 1959</u> , that I last saw the deceased alive on <u>Jan 25, 1959</u> , and that death occurred at <u>2:15 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>2501 1st St</u> DATE SIGNED <u>6/26/59</u> ACTUAL SIGNATURE <u>E. A. Baumgartner</u> M.D. <u>E. A. BAUMGARTNER</u> PHYSICIAN'S NAME (Type) <u>E. A. BAUMGARTNER</u> <u>DALLAND - M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 28, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cooks Mills Cemetery Hyndman, Pa.</u>		22d. LOCATION (City, town, or county) <u>RD#1</u> (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harvey H. Reigler</u> ADDRESS <u>Hyndman, Pa.</u>		24a. REC'D BY REGISTRAR <u>DATE JUN 30 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Klaus</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

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# Item 2 Film G244 7-20-59 et

6806

## CERTIFICATE OF DEATH

06796

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <b>GARRETT</b> <b>MARYLAND</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>GARRETT</b>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OAKLAND</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Swanton</b>									
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>GARRETT COUNTY MEMORIAL HOSPITAL</b>		d. STREET ADDRESS <b>REDACTED</b>									
<b>3. NAME OF DECEASED</b> (Type or print) <b>LILLIE MAE MASON</b>		<b>4. DATE OF DEATH</b> Month <b>JUNE</b> Day <b>27</b> Year <b>1959</b>									
<b>5. SEX</b> <b>FEMALE</b>	<b>6. COLOR OR RACE</b> <b>WHITE</b>	<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>SEPT. 6, 1878</b>								
<b>9. AGE</b> (In years last birthday) <b>80</b> yrs. <table border="1"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> </tr> <tr> <td></td> <td>Hours</td> </tr> <tr> <td></td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months	Days		Hours		Min.	<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>HOUSEKEEPER</b>	
IF UNDER 1 YEAR	IF UNDER 24 HRS.										
Months	Days										
	Hours										
	Min.										
<b>11. BIRTHPLACE</b> (State or foreign country) <b>MARYLAND</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>									
<b>13. FATHER'S NAME</b> <b>RUCKNER FAIRFAX MASON</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>CLARA BELLE WELCH</b>									
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>UNKNOWN</b> (If yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <b>---</b>									
<b>17. INFORMANT</b> <b>CHARLES C. MASON, MT. LAKE PARK, MD.</b>		<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>arteriosclerosis</b> DUE TO (b) <b>arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)									
<b>19. INTERVAL BETWEEN ONSET AND DEATH</b> <b>6 yrs</b>		<b>20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>									
<b>21. MEDICAL CERTIFICATION</b> 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>									
<b>21. I certify that I attended the deceased from</b> <b>JUNE 22,</b> 19 <b>59</b> , <b>to</b> <b>JUNE 27,</b> 19 <b>59</b> , <b>that I last saw the deceased</b> <b>olive on</b> <b>JUNE 26,</b> 19 <b>59</b> , <b>and that death occurred at</b> <b>4:20 AM,</b> <b>from the causes and on the date stated above.</b>											
<b>ACTUAL SIGNATURE</b> <b>Andrew E. Mance</b> <b>M.D.</b>		<b>ADDRESS</b> (Street, city or town, state) <b>Oakland Md</b> <b>DATE SIGNED</b> <b>27 June 59</b>									
<b>PHYSICIAN'S NAME</b> (Type) <b>DR. ANDREW E. MANCE, M.D.</b>		<b>ADDRESS</b> <b>OAKLAND, MD.</b>									
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>	<b>22b. DATE THEREOF</b> <b>6/29/1959</b>	<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>North Glade Cemetery</b>	<b>22d. LOCATION</b> (City, town, or county) (State) <b>near Swanton, Md.</b>								
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>H. Leighton</b>		<b>ADDRESS</b> <b>Oakland, Md.</b>	<b>24a. REC'D BY REGISTRAR</b> <b>DATE JUL 1 '59</b>								
<b>24b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Hines</b>											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 6807 CERTIFICATE OF DEATH

06797

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Garrett</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Garrett</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Deer Park,</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>x Rural Deer Park,</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>4 Mi. No. Deer Park, Md.</b>		d. STREET ADDRESS <b>4 Mi. North</b>	
3. NAME OF DECEASED (Type or print) First <b>Andrew</b> Middle <b>Thomas</b> Last <b>Miller</b>		4. DATE OF DEATH Month <b>June</b> Day <b>13</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 24, 1890</b>
9. AGE (In years last birthday) <b>68</b> yrs.		IF UNDER 1 YEAR Months <b></b> Days <b></b> Hours <b></b> Min. <b></b>	IF UNDER 24 HRS. Months <b></b> Days <b></b> Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Wood Working</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles Miller</b>		14. MOTHER'S MAIDEN NAME <b>Mary Ann Johnson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>218-12-5125</b>	
17. INFORMANT Address <b>Mrs. Hazel Glass R.D. Deer Park, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>527.1 Congestive Heart Failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Emphysema - Chronic</b> DUE TO (c) <b></b>			INTERVAL BETWEEN ONSET AND DEATH <b>6 hours</b> <b>10 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b></b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 12, 1959</b> to <b>June 13, 1959</b> , that I last saw the deceased alive on <b>June 12, 1959</b> , and that death occurred at <b>8:30 A.</b> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Herbert H. Leighton</b> M.D.		ADDRESS (Street, city or town, state) <b>77 Oak Street, Oakland, Md.</b> DATE SIGNED <b>14 June 59</b>	
PHYSICIAN'S NAME (Type) <b>Herbert H. Leighton, M. D.</b>		<b>Oakland, Maryland.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/15/1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Thayerville Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Garrett Co., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. Leighton</b> ADDRESS <b>Oakland, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 16 '59</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician. TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





**MEDICAL CERTIFICATION**

VS A15 (4)  
15M 9/5B

STATE DEPARTMENT OF HEALTH - BUREAU OF  
CERTIFICATE OF DEATH

6408

RECEIVED  
JUL 31 1964

DATE OF DEATH: JUL 10, 1964

TIME OF DEATH: 10:00 A.M.

PLACE OF DEATH: HOME

CAUSE OF DEATH: HEART DISEASE

IMMEDIATE CAUSE OF DEATH: MYOCARDIAL INFARCTION

UNDERLYING CAUSE OF DEATH: CORONARY ARTERY DISEASE

OTHER CAUSE OF DEATH: HYPERTENSION

DEATH CERTIFICATE NO. 6408

REGISTRATION NO. 123456

DATE OF REGISTRATION: JUL 15, 1964

REGISTRATION OFFICE: BUREAU OF VITAL STATISTICS

REGISTRATION OFFICER: J. D. SMITH

REGISTRATION OFFICER'S SIGNATURE: J. D. SMITH

REGISTRATION OFFICER'S TITLE: REGISTRAR

6809

CERTIFICATE OF DEATH

06799

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>GARRETT</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>GARRETT</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>VINDEX</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Vindex</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>WEST VINDEX</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JAMES</b> Middle <b>WILLIAM</b> Last <b>NELSON</b>		4. DATE OF DEATH Month <b>JUNE</b> Day <b>22</b> Year <b>1959</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>APRIL 3, 1872</b>
9. AGE (In years (day birthday) yrs.) <b>87</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during part of working life, even if retired) <b>MINER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>COAL MINES</b>	
11. BIRTHPLACE (State or foreign country) <b>GRANT CO., W.VA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>PHILIP NELSON</b>		14. MOTHER'S MAIDEN NAME <b>NANCY — Not Known</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>NONE</b>	
17. INFORMANT <b>Mrs. Tenna Paugh, R#1, Swanton, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1 Acute Corning Thrombosis</b> DUE TO (b) <b>Corning Heart Disease</b> DUE TO (c) <b>54</b>		INTERVAL BETWEEN ONSET AND DEATH <b>54</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 1950</b> to <b>June 22, 1957</b> , that I last saw the deceased alive on <b>June 22, 1957</b> , and that death occurred at <b>4:30 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Ralph Calandrella</b>		ADDRESS (Street, city or town, state) <b>M.D. Kitzmiller, Md.</b>	
PHYSICIAN'S NAME (Type) <b>Dr. Ralph Calandrella, M.D.</b>		<b>Kitzmiller, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6/25/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Zion Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>R#1, Swanton, Garrett Co. Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>H.C. Keightley</b>		ADDRESS <b>Oakland, Md.</b>	
24a. REC'D BY REGISTRAR <b>JUN 29 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kress</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

## CERTIFICATE OF DEATH

2203

Mexico

RECORDED

INDEXED

Death Certificate  
 (Name of the deceased)

2203  
 2/2

21 June 20  
 12 11 11  
 (Signature)



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 6810 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06800

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Garrett</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland.</b> b. COUNTY <b>Garrett</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Swanton,</b>			c. LENGTH OF STAY IN 1b <b>63 yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Rural Swanton</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>1 Mile west of Swanton</b>				d. STREET ADDRESS <b>1 Mile west, on farm</b>			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Lewis</b> Last <b>Otto</b>				4. DATE OF DEATH Month <b>June</b> Day <b>17,</b> Year <b>19 59</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 6, 1896</b>		9. AGE (In years last birthday) <b>63</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter &amp; Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Farm</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William H. Otto</b>				14. MOTHER'S MAIDEN NAME <b>Mary Elizabeth O'Brien</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>220-16-5864</b>		17. INFORMANT Address <b>Miss Nina Otto Swanton, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>420.1 IMMEDIATE CAUSE (a) Myocardial Infarction, acute</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO INTERVAL BETWEEN ONSET AND DEATH <b>Minutes</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Myocardial infarction March 1958</b>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>James H. Feaster, Jr.</i> EXAMINER'S NAME (Type) <b>James H. Feaster, Jr., M. D.</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			DATE SIGNED <b>6-17-59</b>
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/20/1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>North Gladd Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>near Swanton, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>H. L. Leighton</i> ADDRESS <b>Oakland, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>JUN 18 '59</b>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. House</i>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35		4. RACE White	
5. DATE OF DEATH April 4, 1968		6. TIME OF DEATH 2:01 PM		7. PLACE OF DEATH Room 306, Federal Bureau of Investigation Building, Washington, D.C.		8. CAUSE OF DEATH Suicide by gunshot wound of the chest	
9. MANNER OF DEATH Suicide		10. SIGNATURE OF MEDICAL EXAMINER [Signature]		11. SIGNATURE OF WITNESS [Signature]		12. SIGNATURE OF CORONER [Signature]	
13. SIGNATURE OF DECEASED [Signature]		14. SIGNATURE OF NEXT OF KIN [Signature]		15. SIGNATURE OF POLICE OFFICER [Signature]		16. SIGNATURE OF JURY [Signature]	
17. SIGNATURE OF DISTRICT ATTORNEY [Signature]		18. SIGNATURE OF CLERK [Signature]		19. SIGNATURE OF CHIEF OF POLICE [Signature]		20. SIGNATURE OF SHERIFF [Signature]	
21. SIGNATURE OF JUDGE [Signature]		22. SIGNATURE OF PROSECUTOR [Signature]		23. SIGNATURE OF DEFENSE ATTORNEY [Signature]		24. SIGNATURE OF JURY [Signature]	
25. SIGNATURE OF JURY [Signature]		26. SIGNATURE OF JURY [Signature]		27. SIGNATURE OF JURY [Signature]		28. SIGNATURE OF JURY [Signature]	
29. SIGNATURE OF JURY [Signature]		30. SIGNATURE OF JURY [Signature]		31. SIGNATURE OF JURY [Signature]		32. SIGNATURE OF JURY [Signature]	
33. SIGNATURE OF JURY [Signature]		34. SIGNATURE OF JURY [Signature]		35. SIGNATURE OF JURY [Signature]		36. SIGNATURE OF JURY [Signature]	
37. SIGNATURE OF JURY [Signature]		38. SIGNATURE OF JURY [Signature]		39. SIGNATURE OF JURY [Signature]		40. SIGNATURE OF JURY [Signature]	
41. SIGNATURE OF JURY [Signature]		42. SIGNATURE OF JURY [Signature]		43. SIGNATURE OF JURY [Signature]		44. SIGNATURE OF JURY [Signature]	
45. SIGNATURE OF JURY [Signature]		46. SIGNATURE OF JURY [Signature]		47. SIGNATURE OF JURY [Signature]		48. SIGNATURE OF JURY [Signature]	
49. SIGNATURE OF JURY [Signature]		50. SIGNATURE OF JURY [Signature]		51. SIGNATURE OF JURY [Signature]		52. SIGNATURE OF JURY [Signature]	
53. SIGNATURE OF JURY [Signature]		54. SIGNATURE OF JURY [Signature]		55. SIGNATURE OF JURY [Signature]		56. SIGNATURE OF JURY [Signature]	
57. SIGNATURE OF JURY [Signature]		58. SIGNATURE OF JURY [Signature]		59. SIGNATURE OF JURY [Signature]		60. SIGNATURE OF JURY [Signature]	
61. SIGNATURE OF JURY [Signature]		62. SIGNATURE OF JURY [Signature]		63. SIGNATURE OF JURY [Signature]		64. SIGNATURE OF JURY [Signature]	
65. SIGNATURE OF JURY [Signature]		66. SIGNATURE OF JURY [Signature]		67. SIGNATURE OF JURY [Signature]		68. SIGNATURE OF JURY [Signature]	
69. SIGNATURE OF JURY [Signature]		70. SIGNATURE OF JURY [Signature]		71. SIGNATURE OF JURY [Signature]		72. SIGNATURE OF JURY [Signature]	
73. SIGNATURE OF JURY [Signature]		74. SIGNATURE OF JURY [Signature]		75. SIGNATURE OF JURY [Signature]		76. SIGNATURE OF JURY [Signature]	
77. SIGNATURE OF JURY [Signature]		78. SIGNATURE OF JURY [Signature]		79. SIGNATURE OF JURY [Signature]		80. SIGNATURE OF JURY [Signature]	
81. SIGNATURE OF JURY [Signature]		82. SIGNATURE OF JURY [Signature]		83. SIGNATURE OF JURY [Signature]		84. SIGNATURE OF JURY [Signature]	
85. SIGNATURE OF JURY [Signature]		86. SIGNATURE OF JURY [Signature]		87. SIGNATURE OF JURY [Signature]		88. SIGNATURE OF JURY [Signature]	
89. SIGNATURE OF JURY [Signature]		90. SIGNATURE OF JURY [Signature]		91. SIGNATURE OF JURY [Signature]		92. SIGNATURE OF JURY [Signature]	
93. SIGNATURE OF JURY [Signature]		94. SIGNATURE OF JURY [Signature]		95. SIGNATURE OF JURY [Signature]		96. SIGNATURE OF JURY [Signature]	
97. SIGNATURE OF JURY [Signature]		98. SIGNATURE OF JURY [Signature]		99. SIGNATURE OF JURY [Signature]		100. SIGNATURE OF JURY [Signature]	

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 6811 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06801

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Garrett</u> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> <span style="float: right;">b. COUNTY <u>Garrett</u></span>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Kitzmiller</u>			c. LENGTH OF STAY IN 1b ---	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X <u>Vindex</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Route 42, 4 Mi. N. Kitzmiller</u>				d. STREET ADDRESS ---		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Ira</u> Middle <u>Everett</u> Last <u>Paugh</u>				<b>4. DATE OF DEATH</b> Month <u>June</u> Day <u>27</u> , Year <u>19 59</u>			
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>Nov. 15, 1930</u>		<b>9. AGE</b> (In years last birthday) <u>28</u> yrs.	<b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u>	<b>IF UNDER 24 HRS.</b> Hours <u>  </u> Min. <u>  </u>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>General</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>Ira Hobart Paugh</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Ethel May Paugh</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u>		<b>16. SOCIAL SECURITY NO.</b> <u>215-26-9783</u>		<b>17. INFORMANT</b> <u>Ethel May Paugh</u>		Address <u>Vindex, Md.</u>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>FRACTURED SKULL</u> <u>823 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CRUSHED CHEST</u> DUE TO (c) <u>  </u>						INTERVAL BETWEEN ONSET AND DEATH <u>IMMEDIATE</u> <u>IMMEDIATE</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>Auto accident, car ran off of road and turned over killing driver.</u>					
<b>20c. TIME OF INJURY</b> Month, Day, Year <u>10:40</u> <u>6-27</u> <u>59</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>Street</u>		<b>20f. (City or town)</b> (County) (State) <u>Rural Vindex, Garrett, Md.</u>	
<b>21. I certify that I took charge of the remains described above, held on Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> <b>and find that death resulted from:</b> Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
<b>ACTUAL SIGNATURE</b> <u>James H. Feaster Jr.</u>				<b>EXAMINER'S NAME (Type)</b> <u>James H. Feaster Jr. M. D.</u>		<b>DATE SIGNED</b> <u>6-27-59</u>	
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>6/29/1959</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Mt. Zion Cemetery</u>		<b>22d. LOCATION (City, town, or county)</b> (State) <u>near Swanton, Md.</u>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>A.C. Leighton</u>				<b>ADDRESS</b> <u>Oakland, Md.</u>		<b>24a. REC'D BY REGISTRAR</b> <u>JUL 1 '59</u>	
<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Evans</u>				<b>24c. REGISTRAR'S SIGNATURE</b> <u>  </u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it shall be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06802

6812

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Garrett</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>WEST VIRGINIA</b> b. COUNTY <b>GRANT</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakland</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BAYARD 85x-3</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>GARRETT COUNTY MEMORIAL HOSPITAL</b>		d. STREET ADDRESS	
3. NAME OF DECEASED <b>Artenchie</b> First <b>Long</b> Middle <b>PENNINGTON</b> Last		4. DATE OF DEATH Month <b>JUNE</b> Day <b>12</b> Year <b>1959</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>NOV. 1, 1884</b>
9. AGE (In years last birthday) <b>74</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House work</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>WEST VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>SAMUEL LONG</b>		14. MOTHER'S MAIDEN NAME <b>Not known</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>-----</b>	
17. INFORMANT <b>BLAKE PENNINGTON</b>		Address <b>BAYARD, W.VA.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion, Acute</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Cardio Vascular Disease</b> DUE TO <b>20 years</b> (c)		INTERVAL BETWEEN ONSET AND DEATH <b>Minutes</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>① Lobar Pneumonia ② Diabetes Mellitus</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>February, 1957</b> to <b>June 12, 1959</b> , that I last saw the deceased alive on <b>June 12, 1959</b> , and that death occurred at <b>5:55 P. M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Herbert H. Leighton</b> M.D.		ADDRESS (Street, city or town, state) <b>77 Oak St. Oakland, Md.</b> DATE SIGNED <b>13 Jan 59</b>	
PHYSICIAN'S NAME (Type) <b>HERBERT H. LEIGHTON, M.D.</b>		<b>77 OAK STREET OAKLAND, MARYLAND</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6/15/1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Lanesville Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Tucker County, W. Va.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. C. Leighton</b>		ADDRESS <b>Oakland, Md.</b>	
24a. REC'D BY REGISTRAR <b>JUN 16 59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	





6813

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06803

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Garrett</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural-Swanton</b>		c. LENGTH OF STAY IN 1b <b>1 day</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Westernport</b>		0143.2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>2 Mi W. Swanton</b>				d. STREET ADDRESS <b>418 Hammond</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Marion</b> Middle <b>Francis</b> Last <b>Reeves</b>				4. DATE OF DEATH Month <b>June</b> Day <b>6</b> Year <b>1959</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 24, 1897</b>		9. AGE (In years last birthday) <b>61 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>District Manager</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>O &amp; A Gas Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Richard Reeves</b>				14. MOTHER'S MAIDEN NAME <b>Mary Frye</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>214-05-8162</b>		17. INFORMANT <b>Mrs Marion Reeves- Westernport, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>DROWNING</b> <b>850 X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <b>Imm.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Apparently fell in the water while refueling his motor. He was fishing alone at the time.</b>					
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>6/ - 1959</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Deep Creek Lake</b>		20f. (City or town) (County) (State) <b>Garrett Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>James H. Feaster, Jr.</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>6-7-59</b>			
EXAMINER'S NAME (Type) <b>James H. Feaster, Jr. M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/10/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Philos</b>		22d. LOCATION (City, town, or county) (State) <b>Westernport Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>E.S. Boal</b>				ADDRESS <b>El. Boal, Westernport, Md</b>		24a. REC'D BY REGISTRAR <b>DATE JUN 9 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Huns</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

# MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED _____		SEX _____		AGE _____	
PLACE OF BIRTH _____		DATE OF BIRTH _____		PLACE OF DEATH _____	
OCCUPATION _____		CAUSE OF DEATH _____		MANNER OF DEATH _____	
TIME OF DEATH _____		DATE OF DEATH _____		PLACE OF INTERMENT _____	
SIGNATURE OF MEDICAL EXAMINER _____		SIGNATURE OF CORONER _____		SIGNATURE OF JURY _____	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH _____		CORONER'S CERTIFICATE OF DEATH _____		JURY'S CERTIFICATE OF DEATH _____	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed, it should be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

6814

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

06804

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Garrett</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oakland,</u>		c. LENGTH OF STAY IN 1b <u>3½ yrs.</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u> 0102.2		d. STREET ADDRESS <u>Paca Street</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Weeks Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Myrtle</u> Middle <u>Mongold</u> Last <u>Simmons</u>		4. DATE OF DEATH Month <u>June</u> Day <u>23</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 1885</u>
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Practical Nurse and</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>House work</u>	
11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jacob Mongold</u>		14. MOTHER'S MAIDEN NAME <u>Martha Pratt</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u>---</u>		16. SOCIAL SECURITY NO. <u>---</u>	
17. INFORMANT <u>Mrs. Vincent Wigger</u>		Address <u>915 Atlantic Ave. Lavale, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>501X</u> <u>Malnutrition</u> DUE TO (b) <u>Bronchitis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>Unseen</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 WEEKS</u> <u>7 MONTHS</u> <u>6 WEEKS</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>JAN 1</u> , 19 <u>57</u> , to <u>JUNE 22</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>JUNE 22</u> , 19 <u>59</u> , and that death occurred at <u>8:55P</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James H. Feaster Jr.</u> M.D. <u>58 2-1st. Oakland, Md.</u>		DATE SIGNED <u>6-25-59</u>	
PHYSICIAN'S NAME (Type) <u>James H. Feaster Jr., M. D.</u>		<u>Oakland, Maryland.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/26/1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>I.O.O.F. Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Elk Garden, W. Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H.C. Leighton</u> ADDRESS <u>Oakland, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 29 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

6815

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

06805

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harvett</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oakland Md.</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Weeks Nursing Home</u>		e. STREET ADDRESS <u>11 Heavenly Terrace</u>	
3. NAME OF DECEASED (Type or print) <u>Carl</u> First Middle Last <u>SPEELMAN</u>		4. DATE OF DEATH <u>6</u> Month <u>20</u> Day <u>19</u> Year <u>59</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 14, 1876</u>
9. AGE (In years last birthday) <u>82</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Shipyard</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self</u>	
11. BIRTHPLACE (State or foreign country) <u>Hazen Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>George Speelman</u>		14. MOTHER'S MAIDEN NAME <u>Phoenix Leanne</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs Anna Molinari</u> Address <u>Cumb. Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> 723.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) <u>Osteo-arthritis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5-20-59</u> , 19 <u>59</u> , to <u>6-20-59</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>6-17-59</u> , 19 <u>59</u> , and that death occurred at <u>11:15A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James H. Feaster, Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>58 2ND. ST., OAKLAND, MD.</u>	
DATE SIGNED <u>6-20-59</u>			
PHYSICIAN'S NAME (Type) <u>JAMES H. FEASTER, JR., M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/23/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Immaculate Mems. Pk.</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Stein Inc.</u> ADDRESS <u>Cumb. Md.</u>		24a. REC'D BY REGISTRAR <u>Arthur S. Kraus</u> DATE <u>JUN 25 '59</u>	
		24b. REGISTRAR'S SIGNATURE	

CERTIFICATE OF DEATH

1933

See back for instructions

<p>1. NAME OF DECEASED</p> <p><i>John Doe</i></p>		<p>2. SEX</p> <p><i>Male</i></p>	
<p>3. AGE</p> <p><i>45</i></p>		<p>4. DATE OF BIRTH</p> <p><i>Jan 15 1888</i></p>	
<p>5. PLACE OF BIRTH</p> <p><i>City of Baltimore, Md.</i></p>		<p>6. OCCUPATION</p> <p><i>Teacher</i></p>	
<p>7. CAUSE OF DEATH</p> <p><i>Heart Disease</i></p>		<p>8. PLACE OF DEATH</p> <p><i>Home</i></p>	
<p>9. DATE OF DEATH</p> <p><i>Dec 10 1933</i></p>		<p>10. TIME OF DEATH</p> <p><i>10:00 AM</i></p>	
<p>11. SIGNATURE OF PHYSICIAN</p> <p><i>John Doe</i></p>		<p>12. SIGNATURE OF REGISTRAR</p> <p><i>John Doe</i></p>	
<p>13. SIGNATURE OF WITNESSES</p> <p><i>John Doe</i></p>		<p>14. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>	
<p>15. SIGNATURE OF FUNERAL HOME</p> <p><i>John Doe</i></p>		<p>16. SIGNATURE OF BURIAL PLACE</p> <p><i>John Doe</i></p>	
<p>17. SIGNATURE OF INTERVIEWER</p> <p><i>John Doe</i></p>		<p>18. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>	
<p>19. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>		<p>20. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>	
<p>21. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>		<p>22. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>	
<p>23. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>		<p>24. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>	
<p>25. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>		<p>26. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>	
<p>27. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>		<p>28. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>	
<p>29. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>		<p>30. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>	
<p>31. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>		<p>32. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>	
<p>33. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>		<p>34. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>	
<p>35. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>		<p>36. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>	
<p>37. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>		<p>38. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>	
<p>39. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>		<p>40. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>	
<p>41. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>		<p>42. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>	
<p>43. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>		<p>44. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>	
<p>45. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>		<p>46. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>	
<p>47. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>		<p>48. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>	
<p>49. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>		<p>50. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>	
<p>51. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>		<p>52. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>	
<p>53. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>		<p>54. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>	
<p>55. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>		<p>56. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>	
<p>57. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>		<p>58. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>	
<p>59. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>		<p>60. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>	
<p>61. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>		<p>62. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>	
<p>63. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>		<p>64. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>	
<p>65. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>		<p>66. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>	
<p>67. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>		<p>68. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>	
<p>69. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>		<p>70. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>	
<p>71. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>		<p>72. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>	
<p>73. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>		<p>74. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>	
<p>75. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>		<p>76. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>	
<p>77. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>		<p>78. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>	
<p>79. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>		<p>80. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>	
<p>81. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>		<p>82. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>	
<p>83. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>		<p>84. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>	
<p>85. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>		<p>86. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>	
<p>87. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>		<p>88. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>	
<p>89. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>		<p>90. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>	
<p>91. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>		<p>92. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>	
<p>93. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>		<p>94. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>	
<p>95. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>		<p>96. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>	
<p>97. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>		<p>98. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>	
<p>99. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>		<p>100. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>	

RECEIVED  
BALTIMORE, MD  
DEC 10 1933

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

6818

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06806

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>GARRETT</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OAKLAND</b>		c. LENGTH OF STAY IN 1b <b>24 hrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		d. STREET ADDRESS <b>13 Decatur St.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>CUPPETT NURSING HOME</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Philip</b> Middle <b>Timbrook</b> Last				4. DATE OF DEATH Month <b>6</b> Day <b>9</b> Year <b>19 59</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 17, 1873</b>		9. AGE (In years last birthday) <b>86 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own farm</b>		11. BIRTHPLACE (State or foreign country) <b>W. Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Taylor Timbrook</b>		Address <b>Cumberland, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>UREMIA</b> <b>442 X</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>MALNUTRITION</b> (c) <b>ARTERIOSCLEROTIC CARDIO-RENAL DISEASE</b> DUE TO cause lost.						INTERVAL BETWEEN ONSET AND DEATH <b>weeks</b> <b>weeks</b> <b>years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>James H. Feaster, Jr.</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <b>JAMES H. FEASTER, JR., M. D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<b>6-9-59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 12, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Ebenezer Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Romney, W. Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Byron Knight</b>				ADDRESS <b>Cumberland, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 11 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers.

6817

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06807

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>GARRET</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>W. VA.</b> b. COUNTY <b>MONONGALIA</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OAKLAND</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>MORGANTOWN (RURAL) 85x-3</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Evans Nursing Home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ROSE</b> Middle <b>Florence</b> Last <b>Wisman</b>		4. DATE OF DEATH Month <b>JUNE</b> Day <b>6</b> Year <b>1959</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JUNE 20, 1880</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Anthony Smith</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Morgan</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		17. INFORMANT Address <b>Brooks Wisman RD Morgantown, W. Va.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>UREMIA</b> <b>442 X</b> DUE TO <b>ARTERIOSCLEROTIC CARDIO RENAL DISEASE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>HYPERTENSION</b> (c) <b>OLD CEREBRAL VASCULAR ACCIDENT</b>			INTERVAL BETWEEN ONSET AND DEATH <b>3 weeks</b> <b>YEARS</b> <b>YEARS</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>6-3-59</b> , 19 <b>59</b> , to <b>6-5-59</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>6-3-59</b> , 19 <b>59</b> , and that death occurred at <b>8:50A-M</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>58 2ND. ST., OAKLAND, MARYLAND</b> DATE SIGNED <b>6-6-59</b>			
ACTUAL SIGNATURE <b>James H. Feaster, Jr.</b> M.D.		PHYSICIAN'S NAME (Type) <b>JAMES H. FEASTER, JR., M.D.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6/8/1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Beverly Hills Memorial Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Morgantown, W. Va.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. Leighton - Oakland</b> ADDRESS		24a. REC'D BY REGISTRAR <b>JUN 8 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Charles L. Hand</b>



10807

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

CERTIFICATE OF DEATH

Form No. 10

<p>1. NAME OF DECEASED                  [Faint text, possibly "John Doe"]</p>		<p>2. SEX                  [Faint text, possibly "Male"]</p>	
<p>3. AGE                  [Faint text, possibly "45 years"]</p>		<p>4. DATE OF BIRTH                  [Faint text, possibly "10-15-1900"]</p>	
<p>5. PLACE OF BIRTH                  [Faint text, possibly "Baltimore, Md"]</p>		<p>6. OCCUPATION                  [Faint text, possibly "Teacher"]</p>	
<p>7. MARITAL STATUS                  [Faint text, possibly "Married"]</p>		<p>8. DATE OF DEATH                  [Faint text, possibly "11-1-1945"]</p>	
<p>9. TIME OF DEATH                  [Faint text, possibly "10:30 AM"]</p>		<p>10. PLACE OF DEATH                  [Faint text, possibly "Home"]</p>	
<p>11. CAUSE OF DEATH                  [Faint text, possibly "Heart Disease"]</p>		<p>12. MANNER OF DEATH                  [Faint text, possibly "Natural"]</p>	
<p>13. SIGNATURE OF PHYSICIAN                  [Faint signature]</p>		<p>14. SIGNATURE OF REGISTRAR                  [Faint signature]</p>	
<p>15. DATE OF SIGNATURE                  [Faint text, possibly "11-1-1945"]</p>		<p>16. PLACE OF SIGNATURE                  [Faint text, possibly "Baltimore, Md"]</p>	

10807  
 11-1-1945  
 BALTIMORE, MD

10807  
 11-1-1945  
 BALTIMORE, MD